

		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040709

Facility Name: Alden Lincoln Rehab & H C Ctr

Address: 504 West Wellington Avenue Chicago 60657
Number City Zip Code

County: Cook

Telephone Number: (773) 281-6200 Fax # (773) 281-6745

IDPA ID Number: 36-4003483

Date of Initial License for Current Owners: 03/01/95

Type of Ownership:

<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County
IRS Exemption Code	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other
	<input type="checkbox"/> "Sub-S" Corp.	
	<input type="checkbox"/> Limited Liability Co.	
	<input type="checkbox"/> Trust	
	<input type="checkbox"/> Other	

In the event there are further questions about this report, please contact:
Name: Steven M. Kroll Telephone Number: (773) 286-3883

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)		(Date)
	(Type or Print Name)	STEVEN M. KROLL	
	(Title)	Chief Financial Officer	
Paid Preparer	(Signed)		(Date)
	(Print Name and Title)		
	(Firm Name & Address)		
	(Telephone)	()	Fax # ()
	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630		

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr

0040709 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	96	Skilled (SNF)	96	35,136	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	96	TOTALS	96	35,136	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	10,016	4,766	5,138	19,920	8
9	SNF/PED					9
10	ICF	10,002	1,589	53	11,644	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,018	6,355	5,191	31,564	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.83%

D. How many bed-hold days during this year were paid by Public Aid? (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES NO x

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES NO x

I. On what date did you start providing long term care at this location? Date started 03/01/95

J. Was the facility purchased or leased after January 1, 1978? YES x Date 03/01/95 NO

K. Was the facility certified for Medicare during the reporting year? YES x NO If YES, enter number of beds certified 33 and days of care provided 4,913

Medicare Intermediary Administar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRAUAL x MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES x NO

Tax Year: 12/31/04 Fiscal Year: 12/31/04 * All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	177,921	13,400	9,600	200,921	421	201,342		201,342			1
2	Food Purchase		188,109		188,109	(20,790)	167,319	(23,020)	144,299			2
3	Housekeeping	94,891	20,278		115,169	140	115,309		115,309			3
4	Laundry	48,179	12,081		60,260	398	60,658		60,658			4
5	Heat and Other Utilities			89,825	89,825		89,825	(230)	89,595			5
6	Maintenance	49,980	910	78,703	129,593	169	129,762	4,479	134,241			6
7	Other (specify):* Related Party Salary							23,343	23,343			7
8	TOTAL General Services	370,971	234,778	178,128	783,877	(19,662)	764,215	4,572	768,787			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,185,618	107,874	3,054	1,296,546	2,200	1,298,746	(34,592)	1,264,154			10
10a	Therapy											10a
11	Activities	53,801	3,500	3,559	60,860		60,860		60,860			11
12	Social Services	40,971			40,971		40,971		40,971			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Related Party Salary							17,456	17,456			15
16	TOTAL Health Care and Programs	1,280,390	111,374	16,213	1,407,977	2,200	1,410,177	(17,136)	1,393,041			16
	C. General Administration											
17	Administrative	75,412			75,412		75,412		75,412			17
18	Directors Fees											18
19	Professional Services			399,375	399,375		399,375	(357,896)	41,479			19
20	Dues, Fees, Subscriptions & Promotions			36,687	36,687		36,687	(31,073)	5,614			20
21	Clerical & General Office Expenses	63,376	13,911	20,035	97,322	293	97,615	45,854	143,469			21
22	Employee Benefits & Payroll Taxes			262,356	262,356	17,169	279,525	(30)	279,495			22
23	Inservice Training & Education											23
24	Travel and Seminar			392	392		392	7,537	7,929			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			89,230	89,230		89,230	167	89,397			26
27	Other (specify):* Related Party Salary			60,258	60,258		60,258	153,559	213,817			27
28	TOTAL General Administration	138,788	13,911	868,333	1,021,032	17,462	1,038,494	(181,882)	856,612			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,790,149	360,063	1,062,674	3,212,886		3,212,886	(194,446)	3,018,440			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			33,704	33,704		33,704	10,542	44,246			30
31	Amortization of Pre-Op. & Org.							999	999			31
32	Interest			131,985	131,985		131,985	(97,833)	34,152			32
33	Real Estate Taxes			51,308	51,308		51,308	32,611	83,919			33
34	Rent-Facility & Grounds			733,220	733,220		733,220		733,220			34
35	Rent-Equipment & Vehicles			2,171	2,171		2,171	12,652	14,823			35
36	Other (specify):*											36
37	TOTAL Ownership			952,388	952,388		952,388	(41,029)	911,359			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		268,775	447,139	715,914		715,914	(146,689)	569,225			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,704	52,704		52,704		52,704			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		268,775	499,843	768,618		768,618	(146,689)	621,929			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,790,149	628,838	2,514,905	4,933,892		4,933,892	(382,164)	4,551,728			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(696)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,294)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(6,860)	21		17
18	Fines and Penalties				18
19	Entertainment	(520)	20		19
20	Contributions	(962)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(13,487)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,258)	27		24
25	Fund Raising, Advertising and Promotional	(28,172)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(212)	20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (112,461)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(171,624)	Various	34
35	Other- Attach Schedule	(98,079)	Pg 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (269,703)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (382,164)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Report Period Beginning:Ending:

ID#0040709

01/01/2004

12/31/2004

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Back out 31.78% of PAC fees from standard IHCA b	\$ (1,510)	20	1
2	Late fees on utilities	(1,960)	5	2
3	Intercompany Interest (GL7031)	(127,452)	32	3
4	Medical Records (GL4977)	(618)	21	4
5	Wage Service Fee (GL4977)	(30)	22	5
6	Back out credit related to prior year (GL7143-Vendor Sett	5,348	21	6
7	Back out real estate tax refund for year 2000-2002	28,143	33	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(98,079)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr

0040709

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,294)	0	0	(21,726)	0	0	0	0	0	0	0	(23,020)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(1,960)	0	1,730	0	0	0	0	0	0	0	0	(230)	5
6	Maintenance	0	0	5,167	0	0	0	(20)	(668)	0	0	0	4,479	6
7	Other (specify):*	0	0	23,343	0	0	0	0	0	0	0	0	23,343	7
8	TOTAL General Services	(3,254)	0	30,240	(21,726)	0	0	(20)	(668)	0	0	0	4,572	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(31,403)	(3,189)	0	0	0	0	0	0	(34,592)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	17,456	0	0	0	0	0	0	0	0	17,456	15
16	TOTAL Health Care and Programs	0	0	17,456	(31,403)	(3,189)	0	0	0	0	0	0	(17,136)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(13,487)	0	(344,409)	0	0	0	0	0	0	0	0	(357,896)	19
20	Fees, Subscriptions & Promotions	(31,376)	0	303	0	0	0	0	0	0	0	0	(31,073)	20
21	Clerical & General Office Expenses	(2,130)	0	19,586	23,636	4,762	0	0	0	0	0	0	45,854	21
22	Employee Benefits & Payroll Taxes	(30)	0	0	0	0	0	0	0	0	0	0	(30)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	7,537	0	0	0	0	0	0	0	0	7,537	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	167	0	0	0	0	0	0	0	0	167	26
27	Other (specify):*	(60,258)	0	200,893	5,544	7,380	0	0	0	0	0	0	153,559	27
28	TOTAL General Administration	(107,281)	0	(115,923)	29,180	12,142	0	0	0	0	0	0	(181,882)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(110,535)	0	(68,227)	(23,949)	8,953	0	(20)	(668)	0	0	0	(194,446)	29

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
(to Sch V, col.7)														
30	Depreciation	0	0	9,144	0	1,398	0	0	0	0	0	0	10,542	30
31	Amortization of Pre-Op. & Org.	0	0	999	0	0	0	0	0	0	0	0	999	31
32	Interest	(128,148)	0	28,350	0	342	1,623	0	0	0	0	0	(97,833)	32
33	Real Estate Taxes	28,143	0	4,144	0	324	0	0	0	0	0	0	32,611	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	12,652	0	0	0	0	0	0	0	0	12,652	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(100,005)	0	55,289	0	2,064	1,623	0	0	0	0	0	(41,029)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(19,680)	(24,859)	(102,150)	0	0	0	0	0	(146,689)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	(19,680)	(24,859)	(102,150)	0	0	0	0	0	(146,689)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(210,540)	0	(12,938)	(43,629)	(13,842)	(100,527)	(20)	(668)	0	0	0	(382,164)	45

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	professional fees	\$ 350,531	Alden Management Services		\$	(350,531)	15
16	V	19	professional fees		Alden Management Services		6,122	6,122	16
17	V	21	genl & admin		Alden Management Services		19,586	19,586	17
18	V	5	utilities		Alden Management Services		1,730	1,730	18
19	V	6	maintenance		Alden Management Services		5,167	5,167	19
20	V	24	travel & seminar		Alden Management Services		7,537	7,537	20
21	V	26	insurance		Alden Management Services		167	167	21
22	V	20	dues & subscriptions		Alden Management Services		303	303	22
23	V	30	depreciation		Alden Management Services		9,144	9,144	23
24	V	31	amortization		Alden Management Services		999	999	24
25	V	33	real estate tax		Alden Management Services		4,144	4,144	25
26	V								26
27	V	35	rent-equip & vehicles		Alden Management Services		12,652	12,652	27
28	V	32	interest		Alden Management Services		28,350	28,350	28
29	V	7	salaries - gen'l serv		Alden Management Services		23,343	23,343	29
30	V	15	salaries - health care		Alden Management Services		17,456	17,456	30
31	V	27	salaries - gen'l admin		Alden Management Services		200,893	200,893	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 350,531			\$ 337,593	\$ * (12,938)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Tube Feeding	\$ 32,407	Pyramid Health Care Services		\$ 10,681	\$ (21,726)	15
16	V	10	Nursing Supply	34,705	Pyramid Health Care Services		3,302	(31,403)	16
17	V	39	Per diems/other supplies	44,728	Pyramid Health Care Services		25,048	(19,680)	17
18	V	21	General & admin		Pyramid Health Care Services		23,636	23,636	18
19	V	27	General & admin - Salaries		Pyramid Health Care Services		5,544	5,544	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 111,840			\$ 68,211	\$ * (43,629)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Drugs	\$ 95,080	Forum Extended Care II		\$ 82,010	\$ (13,070)	15
16	V	10	House Stock	983	Forum Extended Care II		848	(135)	16
17	V	39	IV	85,763	Forum Extended Care II		73,974	(11,789)	17
18	V								18
19	V	21	G & A		Forum Extended Care II		4,762	4,762	19
20	V	32	Interest		Forum Extended Care II		342	342	20
21	V	33	Real Estate taxes		Forum Extended Care II		324	324	21
22	V	30	Depreciation		Forum Extended Care II		1,398	1,398	22
23	V	27	General & admin - Salaries		Forum Extended Care II		7,380	7,380	23
24	V	10	Pharmacy Consulting	3,054	Forum Extended Care II			(3,054)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 184,880			\$ 171,038	\$ * (13,842)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	Therapy	\$ 440,026	Community Physical Therapy		\$ 337,876	\$ (102,150)	15
16	V	32	Interest		Community Physical Therapy		1,623	1,623	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 440,026			\$ 339,499	\$ * (100,527)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS & MAINTENANCE	\$ 13,618	ALDEN BENNETT CONSTRUCTION		\$ 13,598	\$ (20)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 13,618			\$ 13,598	\$ * (20)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	CARPET CLEANING	\$	ALDEN REALTY - CARPET CARE		\$	\$	15
16	V	6	FLOOR CLEANING	6,860	ALDEN REALTY - FLOOR CARE		6,192	(668)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 6,860			\$ 6,192	\$ * (668)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number

ALDEN NURSING CENTER - LINCOLN PARK

004-0709

Report Period Beginning 01/01/04

Ending: 12/31/04

RELATED NURSING HOMES	
Name	City
Note: ANC = Alden Nursing Center	
ANC Lakeland	Chicago
ANC Long Grove	Long Grove
ANC Heather	Harvey
ANC Waterford	Aurora
ANC Northmoor	Chicago
ANC Town Manor	Chicago
ANC Terrace of McHenry	McHenry
ANC Morrow	Chicago
ANC Wentworth	Chicago
ANC Naperville	Naperville
ANC Valley Ridge	Bloomingtondale
ANC Village for Children & Young Adults	Bloomingtondale
ANC Orland Park	Orland Park
ANC Princeton	Chicago
Alden of Old Town East	Bloomingtondale
Alden of Old Town West	Bloomingtondale
Alden Trails	Bloomingtondale
Alden Northshore	Skokie
ANC Des Plaines	Des Plaines
ANC Des Plaines II	Des Plaines
ANC Alma Nelson	Rockford
ANC Park Stratmoor	Rockford
ANC Meadow Park	Rockford
ANC Poplar Creek	Hoffman Estates
ANC Governors' Park	Barrington
ANC Gardens of Rockford	Rockford

OTHER RELATED BUSINESS ENTITIES		
Name	City	Type of Business
The Forum Prof. Center	Chicago	Office rental
Pyramid Health Care	Chicago	Nursing supplies
Forum Extended Care II	Chicago	Pharmacy
Alden Management	Chicago	Management
Alden Estates of Evanston	Evanston	Assisted living
Community Physical Therapy	Wood Dale	Therapy provider
Courts of Waterford	Aurora	Alzheimers unit
Gardens of Waterford	Aurora	Assisted living

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd A. Schlossberg	President	CEO	100.00	221,462	1.108	2.77	salary	\$ 6,302	27-7	1
2	Lauren Magnussen	Clinical Coordinator	Nursing	A	71,514	1.108	2.77	salary	2,035	15-7	2
3	Terry Magnussen	Maintenance Supr	Maint.	A	48,616	1.108	2.77	salary	1,384	7-7	3
4											4
5											5
6	a. President and sole stockholder of Alden Management Services, Inc.										6
7	b. Daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										7
8	c. Son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 9,721		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr # 0040709 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Alden Management Services, Inc.
Street Address 4200 W Peterson Ave.
City / State / Zip Code Chicago, IL 60646
Phone Number (773) 286-3883
Fax Number (773) 286-3743

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1		see page 8A (also on page 6A)				\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Therapeutic Systems		x	working capital			\$					\$ 4,533	1
2													2
3													3
4													4
5													5
	Working Capital												
6	related party-ams & ams therap	x		working capital								28,350	6
7	related party-cpt	x		working capital								1,623	7
8	related party-feeII	x		working capital								342	8
9	TOTAL Facility Related						\$					\$ 34,848	9
	B. Non-Facility Related*												
10	offset Interest expense with Interest Income (GL4946,4975)											(696)	10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$ (696)	14
15	TOTALS (line 9+line14)						\$					\$ 34,152	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2003 report.				\$	155,000 1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)				\$	115,451 2
3. Under or (over) accrual (line 2 minus line 1).				\$	(39,549) 3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)				\$	119,000 4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)				\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.					
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)				\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.				\$	79,451 7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1999	161,182	8	
		2000	145,292	9	
		2001	149,072	10	
		2002	150,743	11	
		2003	115,451	12	
accrual based on 3% increase over prior year bill.					
				13	FROM R. E. TAX STATEMENT FOR 2003 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAMEAlden Lincoln Rehab & H C CtrCOUNTYCook

FACILITY IDPH LICENSE NUMBER0040709

CONTACT PERSON REGARDING THIS REPORTSteven M. Kroll

TELEPHONE(773) 286-3883FAX #:(773) 286-3743

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1. 14-28-108-023-0000	Nursing home facility	\$ 115,451	\$ 115,451
2.	Related Party - Alden Management	\$ 149,765	\$ 4,144
3.	Related Party - Forum	\$ 13,827	\$ 324
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 279,043.00	\$ 119,919.00

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

32,252

B. General Construction Type:

Exterior

Brick

Frame

Steel

Number of Stories

3

C. Does the Operating Entity?

☐

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☒

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☐

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

Facility Name & ID Number Alden Lincoln Rehab & H C Ctr

0040709

Report Period Beginning:

01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related party-Forum			1978	\$ 16,213	\$	22	\$	\$	\$ 16,213	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sprinkler heads			1995	1,832	73	25	73		678	9
10	Roof repairs			1995	2,000	200	10	200		1,833	10
11	Installed Electric AMPS			1996	1,870		5			1,870	11
12	Signs			1996	1,800	180	10	180		1,515	12
13	Water Heater			1997	6,180		5			6,180	13
14	Replace Pipes			1997	5,949		5			5,949	14
15	Exhaust Fans			1997	8,403		5			8,403	15
16	Washing machine motor			1998	1,576	197	8	197		1,346	16
17	ABC (General construction) Major repairs/improvement			1999	5,713	571	10	571		3,142	17
18	ABC (General construction) Major repairs/improvement			1999	2,326	233	10	233		1,260	18
19	ABC (General construction) Major repairs/improvement			1999	2,092	209	10	209		1,133	19
20	ABC (General construction) Major repairs/improvement			1999	1,870	187	10	187		966	20
21	ABC (General construction) Major repairs/improvement			1999	12,658	1,266	10	1,266		6,540	21
22	ABC (General construction) Major repairs/improvement			1999	2,250	225	10	225		1,144	22
23	ABC (General construction) Major repairs/improvement			1999	10,225	1,022	10	1,022		5,198	23
24	Climate Services (exhaust fan)			1999	2,280	342	5	342		2,280	24
25	Oxygen exhaust system			2000	8,555	1,069	8	1,069		5,258	25
26	Elevator door repair			2000	1,518	304	5	304		1,367	26
27	Lawn Sprinkler			2000	15,500	620	25	620		2,687	27
28	ABC (General construction) Major repairs/improvement			2000	6,937	1,387	5	1,387		5,781	28
29	ABC (General construction) New hot water system			2000	49,596	2,480	20	2,480		11,986	29
30	ABC (General construction) Replace showers			2000	23,903	2,390	10	2,390		10,358	30
31	Replace Fire Pump			2001	3,230	162	20	162		646	31
32	14 Kilowatt water heater booster			2001	2,783	278	10	278		928	32
33	ABC (General construction) Major repairs/improvement			2001	3,402	680	5	680		2,381	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Capps Plumbing (pipe & wall repair)	2002	\$ 1,985	\$ 397	5	\$ 397	\$	\$ 893	37
38	ABC (misc construction work)	2002	3,442	688	5	688		1,606	38
39	ABC (repair ejector pump)	2002	7,893	1,579	5	1,579		3,552	39
40	Capps Plumbing (water pump)	2002	3,275	164	20	164		396	40
41	TNS (DSL Cable)	2004	1,358	249	5	249		249	41
42	ABC (1st Floors Stairs)	2004	1,699	14	10	14		14	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 220,313	\$ 17,167		\$ 17,167	\$	\$ 113,750	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 220,313	\$ 17,167		\$ 17,167	\$	\$ 113,750	1
2	Related Party-Forum:								2
3	Leasehold Improvement-Remodeling	1980	12,303		15			12,303	3
4	Leasehold Improvement-Remodeling	1980	19,273		20			19,273	4
5	Leasehold Improvement-Tenant Improvement	1987	996		13			996	5
6	Leasehold Improvement-AMS Remodel	1988	14,339		10			14,339	6
7	Leasehold Improvement-Roof	1994	3,572	223	16	223		2,234	7
8	Leasehold Improvement-Build.Improv.	1996	1,259	79	16	79		704	8
9	Leasehold Improvement-Asphalting	2000	98		3			98	9
10	Leasehold Improvement-DAI	2001	172	17	10	17		54	10
11	Leasehold Improvement-Bathrooms	2002	733	82	7	82		181	11
12	Leasehold Improvement-Suite Renovation	2003	1,638	164	10	164		328	12
13	Leasehold Improvement-Plumbing, Construct, Concrete, Doors, etc	2004	1,820	148	7	148		148	13
14	Leasehold Improvement-Add-on Improvement, fixture base	1980	79		23			79	14
15	Leasehold Improvement-Add-on Improvement, lighting base	2001	137	27	5	27		103	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	Related Party-AMS:								25
26	Leasehold Improvement-Remodeling	1993	5,938		7			5,938	26
27	Leasehold Improvement-Remodeling	2002	4,861	608	7	608		1,215	27
28	Leasehold Improvement-Remodeling	2003	5,085	775	7	775		1,394	28
29									29
30									30
31									31
32	Forum Extended Care, LLC-building/building improv	1999	13,393	266	30	266		2,041	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 306,009	\$ 19,556		\$ 19,556	\$	\$ 175,179	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$174,541	\$20,836	\$20,836	\$	various	\$86,609	71
72	Current Year Purchases	13,802	1,330	1,330		various	1,330	72
73	Fully Depreciated Assets	81,822	2,394	2,394		various	81,822	73
74								74
75	TOTALS	\$270,165	\$24,560	\$24,560	\$		\$169,761	75

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76	car engine/bus/van	various/dodge	98-'04	\$8,164	\$130	\$130	\$	3	\$7,981
77									77
78									78
79									79
80	TOTALS			\$8,164	\$130	\$130	\$		\$7,981

E. Summary of Care-Related Assets				1	2
		Reference			Amount
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$584,338
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$44,246
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$44,246
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$352,921

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:TL Enterprises
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.☒ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		96	3/1/95	\$ 733,220	15		3
4	Additions							4
5								5
6								6
7	TOTAL		96		\$ 733,220			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease.

9. Option to Buy:☒ YES☐ NO Terms:purchase option deposit*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?☐ YES☒ NO
16. Rental Amount for movable equipment: \$ 2,171 Description:Copy Machine lease \$2,171
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19	related party - AMS	various	#####	12,652	19
20					20
21	TOTAL		\$ #####	\$ 12,652	21

10. Effective dates of current rental agreement:

Beginning3/1/95

Ending3/1/10

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	\$ 728,248
13.	/2006	\$ 728,248
14.	/2007	\$ 728,248

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

Skilled nurses on site

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☐

☐

B. EXPENSES		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED	
COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 221,689	\$		\$ 221,689	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			11,739			11,739	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			206,597			206,597	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See Page 16A	# of prescrpts				70,221		70,221	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39-1,39-3								12
13	Other (specify):	See page 16A				(102,150)	161,129		58,979	13
14	TOTAL			\$		\$ 337,875	\$ 231,350		\$ 569,225	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Page 16
Col 5: PT,OT, & ST
Col 6: Other
Amount

XIV. SPECIAL SERVICES (Direct Cost)

Service

1. OT	39-3	\$221,689.36
2. ST	39-3	11,738.75
3.		
4. PT	39-3	206,597.12
5.		
6.		
7.		
8.		
9. Phamacy	See pg 16A	95,079.78
Plus: Related Party- Forum Drugs		(13,070.00)
Plus: Related Party- Forum I.V.		(11,789.00)
Total to line 9 Pharmacy		70,220.78
10.		
11.		
12. Exceptional Care-Column 3	See pg 16A	0.00
12. Exceptional Care-Column 6	See pg 16A	
13. Other:Lab, x-ray therapy, Mattress, Pyramid billings		168,952.41
Oxygen Cost - IDPA		11,857.00
Related Party- Pyramid		(19,680.00)
Related Party- CPT		(102,150.00)
Total to line 13		58,979.41
14. Total		569,225.42

=====

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 95,000)	709,346		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,313		6
7	Other Prepaid Expenses	11,408		7
8	Accounts Receivable (owners or related parties)	2,092,031		8
9	Other(specify): Due from 3rd parties	71,434		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,889,532	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	284,413		15
16	Equipment, at Historical Cost	191,692		16
17	Accumulated Depreciation (book methods)	(282,074)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	145,662		21
22	Other Long-Term Assets (specify):	288,000		22
23	Other(specify): Purchase Options			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 627,693	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,517,225	\$	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 1,343,621	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	214,464		28
29	Short-Term Notes Payable	35,952		29
30	Accrued Salaries Payable	172,287		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,993		31
32	Accrued Real Estate Taxes(Sch.IX-B)	119,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	accr ins, exps, idpa, sales tax,etc	328,727		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,224,044	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	12,809		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 12,809	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,236,853	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,280,372	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,517,225	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,029,746	1
2	Restatements (describe):		2
3	external audit adjustments made after 2003 cost report was	2,033	3
4	submitted. These have no effect on prior years report :		4
5	Telephone expense		5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,031,779	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	248,593	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 248,593	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,280,372	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,985,343	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,985,343	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	129,599	6
7	Oxygen	16,155	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 145,754	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	(1,216)	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	503	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	125	19
20	Radiology and X-Ray		20
21	Other Medical Services	49,925	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 49,337	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	696	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 696	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Medical Records,Wage Service Fee	648	28
28a	Write off of Old Amounts Due (related to prior yr,not offst	707	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,355	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,182,485	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	783,877	31
32	Health Care	1,407,977	32
33	General Administration	1,021,032	33
	B. Capital Expense		
34	Ownership	952,388	34
	C. Ancillary Expense		
35	Special Cost Centers	715,914	35
36	Provider Participation Fee	52,704	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 4,933,892	40
41	Income before Income Taxes (line 30 minus line 40)**	248,593	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 248,593	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,438	1,462	\$ 49,122	\$ 33.60	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,634	13,158	377,685	28.70	3
4	Licensed Practical Nurses	11,019	11,482	237,478	20.68	4
5	Nurse Aides & Orderlies	43,795	47,859	460,531	9.62	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,080	2,080	34,890	16.77	9
10	Activity Assistants	2,139	2,235	18,910	8.46	10
11	Social Service Workers	1,928	2,080	40,971	19.70	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	39,351	18.92	13
14	Head Cook	1,896	2,024	26,178	12.93	14
15	Cook Helpers/Assistants	10,846	11,945	112,393	9.41	15
16	Dishwashers					16
17	Maintenance Workers	1,880	2,080	49,980	24.03	17
18	Housekeepers	9,413	10,050	94,890	9.44	18
19	Laundry	5,483	6,070	48,179	7.94	19
20	Administrator	2,032	2,080	75,412	36.26	20
21	Assistant Administrator					21
22	Other Administrative	1,904	2,080	42,735	20.55	22
23	Office Manager					23
24	Clerical	2,376	2,561	20,641	8.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,136	2,136	39,460	18.47	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Alzheimers Aid</u>	2,173	2,269	21,343	9.41	33
34	TOTAL (lines 1 - 33)	117,172	125,731	\$ 1,790,149 *	\$ 14.24	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 9,600	1-3	35
36	Medical Director	Monthly	9,600	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,304	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	25	1,344	11-3	44
45	Social Service Consultant	13	690	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	38	\$ 23,538		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ n/a		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount	
Tess Sagaidoro	Administrator		\$ 75,412	Workers' Compensation Insurance		\$ 35,039	IDPH License Fee	\$	
				Unemployment Compensation Insurance		18,201	Advertising: Employee Recruitment	802	
				FICA Taxes		135,656	Health Care Worker Background Check		
related party-various				Employee Health Insurance		16,969	(Indicate # of checks performed 13)	92	
executives	exec mgmt			Employee Meals		20,790	Surety Bond Fees	280	
				Illinois Municipal Retirement Fund (IMRF)*			IL. Healthcare Assoc.	3,242	
				Chicago Head Tax		3,692	Secretary of State (Dues & Subscriptions)	200	
				Union Health & Welfare		39,991	DTCPub Healthcare Times (Dues & Subscrip	55	
				Dental, Life & Pension		13,575	IL. Assoc of Healthcare, AMS Billings (Dues	640	
TOTAL (agree to Schedule V, line 17, col. 1)				Misc, Tution		(6,268)	Related Party - AMS	303	
(List each licensed administrator separately.)			\$ 75,412	Drug Tests, 401K Match, Vaccinations		1,850	Less: Public Relations Expense	()	
B. Administrative - Other							Non-allowable advertising	()	
Description			Amount				Yellow page advertising	()	
			\$				TOTAL (agree to Sch. V, line 20, col. 8)		
							\$ 5,614		
				TOTAL (agree to Schedule V, line 22, col.8)					
TOTAL (agree to Schedule V, line 17, col. 3)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
(Attach a copy of any management service agreement)									
C. Professional Services									
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount	
AMS	Management Fees		\$ 350,531			\$	Out-of-State Travel	\$	
BDO Seidman	Accounting Fees		11,544						
Ken Fisch / Barry Greenburg	Legal Services		25,490						
Schmidt Salzman	Legal Services-Tax Refund		9,408				In-State Travel		
Administar	Billing Services		1,980				Auto & Travel	142	
Medi.Com	Billing Consultants		422				related party-AMS	7,537	
							Seminar Expense		
							Alzheimer's Association	250	
							Entertainment Expense	()	
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V, line 24, col. 8)		
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 399,375				TOTAL		
							\$ 7,929		

*** Attach copy of IMRF notifications**

****See instructions.**

Facility Name & ID Number Alden Nursing Center - Lincoln Park Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year							FY2008	FY2009
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007		
1	Climate Serv (repair boiler)	Feb-97	1,644	3									
2	Climate Serv (repair/insulate pip	Apr-97	2,348	3									
3	Climate Serv(insulation-remove	Jun-97	3,865	3									
4	Climate Serv(install circulating p	Sep-97	2,585	3									
5	Appliance(air conditioning for ki	Aug-97	2,412	3									
6	Great L.P.(remove & install pun	Dec-97	2,595	3									
7	Appliance C.(a/c for kitchen)	May-98	3,702	3	411								
8	CSI(install ductwork for dryer e	Sep-98	2,670	3	593								
9	Custom A.C. (carpeting)	Dec-98	2,940	3	898								
10	Custom A.C.	Dec-98	192	3	59								
12	ABC(repair floor and roof)	9/00	10,285	3	3,428	3,428	2,286						
13	ABC(misc. construction job)	11/00	8,927	3	2,975	2,976	2,480						
14	GT Mechanical(replace motor)	11/02	1,122	3		62	374	374	312				
15	Painting > \$1,500 --1999	7/99	11,700	3	3,900	1,950							
16	Painting > \$1,500 --2000	7/00	6,413	3	2,138	2,138	1,069						
17													
18													
19	Totals from Page 22 . . .		35,026		343	343	343	343	343	343	343	343	343
20	GRAND TOTALS		98,425		14,747	10,897	6,552	717	655	343	343	343	343

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

yes
- (2)

Are there any dues to nursing home associations included on the cost report?
If YES, give association name and amount.

yes
IL Healthcare Assoc. \$4,752
- (3)

Did the nursing home make political contributions or payments to a political action organization?
If YES, have these costs been properly adjusted out of the cost report?

yes
yes
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?
If YES, what is the capacity?

no
- (5)

Have you properly capitalized all major repairs and equipment purchases?
What was the average life used for new equipment added during this period?

yes
10 yrs
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 20,540 Line 10
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?
If NO, attach a complete explanation.

yes
- (8)

Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

no
- (9)

Are you presently operating under a sublease agreement?

YES no NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO
If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

x
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.
This amount is to be recorded on line 42 of Schedule V.

\$ 52,704
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?
If YES, attach an explanation of the allocation.

no

- (13)

Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

yes
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?
For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

no
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.
Has any meal income been offset against related costs?

\$ 20,790
no

Indicate the amount. \$ n/a
- (16)

Travel and Transportation

a.

Are there costs included for out-of-state travel?
If YES, attach a complete explanation.

no

b.

Do you have a separate contract with the Department to provide medical transportation for residents?
If YES, please indicate the amount of income earned from such a program during this reporting period.

no

c.

What percent of all travel expense relates to transportation of nurses and patients?

0

d.

Have vehicle usage logs been maintained?

yes

e.

Are all vehicles stored at the nursing home during the night and all other times when not in use?

yes

f.

Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

yes

g.

Does the facility transport residents to and from day training?
Indicate the amount of income earned from providing such transportation during this reporting period.

no
\$ n/a

(17)

Has an audit been performed by an independent certified public accounting firm?
Firm Name:
The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?
If no, please explain.

yes
BDO Seidman, LLP
not yet completed

(18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

yes

(19)

If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees.

yes

From Line	To Line	Amount	Description
2		(20,790)	Employee Meal
	22	20,790	Employee Meal
22		(3,621)	Uniforms
	10	2,200	Uniforms
	6	169	Uniforms
	4	398	Uniforms
	1	421	Uniforms
	3	140	Uniforms
	11		Uniforms
	21	293	Uniforms
		<u>0</u>	Net should be 0
			-401